

The ins and outs of patient abandonment

As a nursing student, you know that you should never “abandon” a patient. But what exactly is patient abandonment? And how do you protect yourself from being accused of this type of unprofessional conduct?

patient abandonment, said Gloria F. Donnelly, PhD, FAAN, RN, Dean of the College of Nursing & Health Professions at MCP Hahnemann University. For example, a student nurse who has been assigned to care for a patient and runs to

facility, the supervising nurse and the nursing program, and the student could face disciplinary action or be terminated from the program.

When patient care is at risk

These examples of patient abandonment may seem straightforward, but other situations are not so cut and dry. What if you're assigned a task or procedure for which you do not feel adequately qualified? Would refusing mean you've abandoned the patient?

The answer is “no,” as long as you refuse in an appropriate manner. It is your responsibility to immediately inform your instructor or preceptor, said Donnelly, and let her negotiate the assignment on your behalf. This may mean amending the assignment to include only tasks for which you have been trained, or ensuring that you receive direct supervision for any procedures that are new to you.

Agreeing to perform a task beyond your skill level would be akin to acting outside your scope of practice, which can lead to severe consequences, including termination from your program or malpractice charges. So, if your instructor fails to step in, take your concerns up the chain of command, all the way to the head of your nursing program, if necessary. Document your objections, including the task you don't feel equipped to handle and why, the training you would need to safely perform the assignment, the person/people with whom you spoke, and the outcome of the situation.


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When a nurse deserts or neglects a patient with whom he or she has an established provider-patient relationship without making reasonable arrangements for continuation of care and without reasonable notice, that nurse may stand accused of patient abandonment.¹ In other words, once you receive report on a specific patient, that patient is your responsibility—until you pass report to another nurse or the patient is transferred or discharged.

Nursing students may not realize how easy it is to meet this definition of

the coffee shop without telling anyone has abandoned his patient. The same is true if he rushes off to meet his instructor at a post-care conference without turning his patient back over to the nursing staff. If the patient were harmed because of the student's absence, a malpractice claim could be filed against the



National Student Nurses' Association

endorses NSO's professional liability insurance

The ins and outs of patient abandonment

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Once you're licensed and working independently, other situations that could be construed as patient abandonment may arise. Let's say that you have just finished a 12-hour shift, only to find out that no other nurse is available to relieve you. On the one hand, you have already accepted report for your patients, establishing the provider-patient relationship. But many states say that refusing mandatory overtime does not constitute patient abandonment. To deal safely with such situations, you must know the rules of your state's Board of Nursing. Often, it's up to you to decide whether or not you can continue providing safe patient care. If not, notify your supervisor of your decision, and write a

memo documenting the specific reasons.²

Whatever the particular situation, you are individually responsible and professionally accountable for the patient care you provide. Nursing students are held to the same standards of care as licensed nurses, so make sure you understand the ins and outs of patient abandonment. This knowledge will equip you to ensure quality patient care—and protect you from a charge of patient abandonment.

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Coverage Corner

News about your Professional Liability Insurance

STUDENT ALERT! Keep your professional liability coverage active after you graduate

One of the most frequently asked questions NSO receives is: Why do I need my own professional liability insurance if my employer already covers me?

You may already understand that your own policy will protect you against malpractice allegations during clinicals, but you also want to make certain that you have sufficient protection if you are named in a lawsuit or need legal defense to respond to a complaint against you with the licensing board after you graduate.

While your employer may provide coverage, it may not cover you in all cases. You need to be clear how your employer's coverage protects you. Often, an employer's policy is designed to protect its interests first. If you have your own policy, you will have the benefit of your own representation that is focused on your interests in the event of a lawsuit.

Some students avoid continuing their own policy because they may have been

told, "having your own insurance will make you a more likely target for a lawsuit." This couldn't be further from the truth. First, a person can sue you any time, for any reason. If a patient perceives he or she has been injured and believes that this injury is the result of your providing, or failing to provide, adequate professional services, that patient could sue. This doesn't mean that you were negligent. It means that the patient perceives negligence. Second, no one can know whether you have your own policy. In fact, this information typically won't be uncovered until the "discovery phase" of the lawsuit. At that point, you will already have been named in the suit.

By continuing your coverage as a licensed nurse, you can feel comfortable knowing that if something happens on or off the job, 24/7, you can rely on your own policy to protect you against allegations of professional malpractice.

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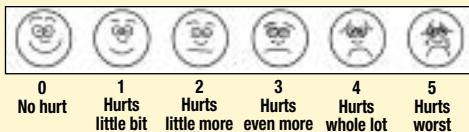
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PAIN MANAGEMENT: RESPONSIBILITIES AND RISK

In 2001, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) implemented pain management standards calling for the recognition of patients' right to pain relief. According to JCAHO, pain is to be treated

Wong-Baker FACES Pain Rating Scale



From Hockenberry MJ, Wilson D, Winkelstein ML: *Wong's Essentials of Pediatric Nursing*, ed. 7, St. Louis, 2005, p. 1259. Used with permission. ©Mosby.

as a fifth vital sign, evaluated along with the patient's pulse, blood pressure, core temperature and respiration.

While caring for your patient, you're responsible for educating him or her about your facility's pain management policies, the pain assessment process, and ways of providing pain relief. To assess for pain, you should use a method that is suitable for the patient's age and abilities. Adolescents or adults may be able to describe their pain and to rate its intensity, using a scale from one to 10 in which 10 represents the worst pain imaginable. For pediatric patients, you might use the FACES scale. Ask a child to show you how much he or she hurts by pointing to one of its six cartoon images, which range from a happy, smiling face to a tearful, sad face. In older adults with cognitive changes, look for signs of pain such as grimaces, agitation, restlessness, inability to sleep, depression or withdrawal.

Once you have identified the level of pain, managing it should become part of the plan of care. Become familiar with the analgesics administered to the patient, including the dose

and dosing interval, duration of action, time of onset and peak effect, and any side effects or contraindications. To ensure the appropriate use of the pain medication, document the patient's response to the drugs and the findings of any follow-up assessments. It's crucial, too, to notify the primary care provider if the pain continues unabated, both to help the patient and to avoid a malpractice charge for undertreatment of pain.

REPORTING ON-THE-JOB INJURIES

In 2003, nurses suffered from more than 20,000 injuries that resulted in missed work, the Bureau of Labor Statistics reports. Needlesticks and musculoskeletal injuries were particularly common. If you are injured at work, be sure to report the injury to your supervisor. Fill out an incident report that includes a description of the accident and resulting injury and its time and date. If you are in an employee-employer relationship, also complete a workers' compensation claim form. Independent contractors and private duty or per diem nurses may not be covered by workers' comp.



Laws vary by state, but workers' comp generally covers medical and hospital bills and provides a percentage of lost pay. Permanent disability usually results in a flat monetary award. But to get any of these benefits, you must complete the workers' comp claim form and submit it within the time specified by law. Be truthful and thorough when answering questions about your claim. The workers' comp carrier will use this information to determine your benefits.

Lessons from Court

⋮ Restraining a patient—carefully

Were these nurses negligent in restraining—or failing to monitor—this patient?

A blind amputee with diabetes was admitted to the hospital, disoriented and confused. Three days later, he was diagnosed with a cerebral stroke. That night, when he tried to get out of bed, the nurses applied a Posey vest. Three hours later, the patient was found, wedged between the mattress and bed rail and unresponsive. Although he was briefly revived, the patient died two hours later.

His estate sued the hospital, claiming that the nurses failed to monitor the patient after restraining him. The defen-

dant denied any negligence and claimed that the death was caused by the stroke. The jury found in favor of the defense.

Staff. (2005). Medical Malpractice Verdicts, Settlements & Experts, 21(7), 17.

Advice from the expert:

Restraining a patient should be a last resort, after other interventions have failed. Nonetheless, cases like these can easily be defended if healthcare providers take precautions whenever they restrain a patient. Restraints, such as the Posey vest, are medical devices regulated by the FDA, and their use requires a clinician's order. The most common mistakes associated with restraints are applying them incorrectly, using the wrong size device, not securing the

restraint to the bed correctly, not checking on the patient frequently and using the restraint for convenience rather than medical necessity. These mistakes can be prevented by educating staff in the proper use of restraints and their application. Nurses should ensure that they follow their facility's protocols for using restraints.

Bottom line: Properly applied and used only as needed, these devices can increase a feeling of safety and greatly reduce the risk of patient injury. Use a restraint only as a last resort—document other interventions that were tried first—and be sure to check on the patient frequently.

Melanie Balestra, JD, MN, NP
Irvine, CA

End-of-life care:

Most patients who die in hospitals spend time in an ICU receiving aggressive, high-tech, costly care. As the widely acclaimed SUPPORT study of some 9,000 hospitalized patients found, however, these final days of life are often filled with unnecessary suffering.¹ The alternative to this scenario is palliative care, which concentrates not on prolonging life but on providing supportive care that promotes patients' comfort and dignity.

Nurses can make a major contribution in easing the transition from aggressive treatment to palliative care, regardless of the setting. To do so, they must be prepared to make ethical and humane decisions and at the same time consider ways to avoid liability.

Who receives palliative care?

The World Health Organization defines palliative care as the "active, total care of patients whose disease no longer responds to curative treatment.... (It) affirms life and regards dying as a normal process...neither hastens nor postpones death... (and) provides relief from pain and other distressing symptoms."² While the precepts of palliative care are rooted in the hospice movement, its delivery need not be limited to patients who are expected to die within six months, as originally conceived by Medicare. Nor should it be offered only to patients enrolled in hospice.

Nursing responsibilities

If your patient is receiving palliative care, you may be part of a healthcare team—and a central player. The makeup of the team varies, but may include—in addition to one or more nurses and the patient's primary care practitioner (PCP)—a social worker, chaplain, pharmacist, dietitian, physical and occupational therapists and other allied health workers.

Nursing tasks include assessing for pain and other distressing symptoms, providing evidence-based interventions to alleviate them, and preventing initiation of interventions that may not improve comfort and quality of life. Nurses also work with team members to attend to the psychological and spiritual dimensions of terminal illness. Finally, nurses must work with family members as they also shift their focus from curing the patient to palliative care. The commitment to family members should continue after the patient's death, with support and referral for counseling, if indicated.

Making choices

End-of-life care is full of choices: Should pneumonia be treated with antibiotics? Would a ventilator alleviate respiratory distress? Should tube feeding be started? Should dialysis be continued? According to the precepts of palliative care, the patient should be at the center of these choices. But what happens if the patient is unconscious, unable to speak or senile and cannot make these choices? That's where the Terri Schiavo case becomes relevant.

To many observers, the lesson of this case—in which the husband and parents battled for years over what kind of care



their loved one should have—is that decisions would have been vastly easier if Ms. Schiavo, despite her youth, had an advanced directive. It could have specified her wishes regarding interventions like the artificial nutrition that kept her alive for all those years. Terri Schiavo might also have had a healthcare proxy (a durable power of attorney for healthcare), clearly defining whom she wished to speak for her when she could not speak for herself. Yet even when such documents are executed and in the medical record, they don't always guarantee that the patient's wishes will be carried out.

Sally Okun, RN, an experienced hospice nurse with the nonprofit Center

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Responsibilities and risks

for Life Care Planning and Support, Hyannis, MA, has developed a more comprehensive solution she calls Advanced Care Planning (ACP), which many hospices have adopted.³ ACP, a type of anticipatory guidance introduced early in the patient's illness, involves both the family members and the patient. "If we can improve communication and lifecare planning earlier in the lifespan [of the patient], each one of us will become more experienced with balancing important health-related decisions, including those near the end of life," Okun believes. In what she calls "lifecare conversations," the patient and family members, working with the interdisciplinary team, discuss the likely course of the illness, and the benefits and drawbacks of available interventions. They work together to define the patient's goals and choose the best means to attain them. Writing an advanced directive, which should be reevaluated periodically, is often a part of this comprehensive process.

What about DNR orders?

Even when the patient has an advanced directive or has clearly said he or she does not wish to receive CPR in a life-threatening situation, CPR is mandatory for respiratory or cardiac arrest—unless the chart contains a PCP's DNR order. It's vital for nurses to help patients and families understand this, to provide information about the odds that the resuscitation efforts will succeed, to find out whether the patient or the designated surrogate wants a DNR order and, if so, to request the order from a PCP.

Risks and ethical dilemmas

End-of-life care often involves choices that are ethically difficult and give rise to fears of potential liability. Withdrawal of life-sustaining treatment such as dialysis or a feeding tube and the need for large or escalating doses of opioids (which can lead to serious adverse effects or even be lethal) or sedatives are particularly troubling issues.

Here's what the ANA says about opioids: "Nurses must use effective doses of medications prescribed for symptom control and nurses have a moral obligation to advocate on behalf of the patient when prescribed medication is insufficiently managing pain and other distressing symptoms. The increasing titration of medication to achieve adequate symptom control is ethically justified."⁴

The Hospice and Palliative Nursing Association takes a similar position regarding the use of potentially lethal sedatives—a practice sometimes called terminal sedation: "For imminently dying patients... whose suffering is unrelenting and unendurable," its position statement says, "... medications intended to induce varying degrees of unconsciousness but not death... may offer relief."⁵

Actions based on these principles are not the same as

euthanasia or assisted suicide, which are not sanctioned by nursing codes of conduct and are illegal in almost every state.

Withholding and withdrawing life-sustaining therapy is also legally and ethically permissible if it is the patient's fully informed and freely made wish—or if the therapy is causing or will cause harm to the patient or offers no benefit to the patient. Artificial nutrition and hydration may be withheld or withdrawn on the same grounds. To avoid liability, however, it is essential to follow your institution's guidelines on these issues, as well as your state's law.

Your role, regardless of the circumstances, is to advocate for the patient's wishes, as expressed in an advanced directive or an advance planning conversation or by the patient's chosen surrogate. The family may want to consult with a psychiatrist, ethicist, chaplain, social worker, pharmacist or palliative care specialist in making an end-of-life care decision. Judy Lentz, RN, CEO of the Hospice and Palliative Nurses Association, noted, "Decisions based on the known desires of the patient and family, as the unit of care, are the guiding directives for the patient plan of care."

If you find yourself in a position where a patient's desire to end life-sustaining interventions conflicts with your own belief system, request that his or her care be transferred to a colleague. As always, thoroughly document any conversations you have with the patient, family or other professionals about end-of-life decisions to protect yourself against potential liability.

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End-of-life care often involves choices that are ethically difficult and give rise to fears of potential liability.”

To read more...

about the expanded role of palliative care in patients with certain chronic illnesses, see the Web Flash in the Newsletter section of www.nso.com.

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Occurrence vs. claims-made: What are the differences?

In the world of professional liability insurance, there are two types of policies, occurrence and claims-made. It's important to understand the difference between the two coverages.

An occurrence policy, like the one currently offered by Nurses Service Organization (NSO), covers you for any incident that occurs during the policy term, regardless of when the claim is filed. As long as the incident occurred during the term that the policy was active, regardless of when you were named in a lawsuit, you are covered.

A claims-made policy also provides coverage for an incident that occurs during an active policy period, but only if the claim is also reported to the insurance company while the policy remains in force or during any applicable extended reporting period (also known as "tail"

coverage). In other words, if you are named in a lawsuit, claims-made coverage will respond only if the date of the incident and the date of the claim are subsequent to your prior acts date and while you have a claims-made policy in force or applicable tail coverage.

What's key with a claims-made policy is that you run the risk of not being covered for a claim discovered after the policy has expired. Therefore, if you decide to terminate a claims-made policy, you will need to purchase tail coverage to continue to protect yourself. This will extend the time that a claim can be reported, but the incident still needs to occur while the policy was active, or you won't be covered.

The bottom line is, learn the details of your coverage so you are not caught unawares. You may be shocked how policies differ from one another.

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Understanding—and preventing—medication errors

A patient who suffers permanent injury from being given the wrong drug is obviously the victim of a medication error. But even when no negative effect results, giving the right drug at the wrong time or via the wrong route constitutes a medication error. So does administering the wrong drug or the wrong dose of the right drug. And, any med error can jeopardize patient safety and increase your risk of liability.

The best way to prevent medication errors is to recognize when they're most likely to happen. If a staffing shortage leaves you busier than usual, for example, you are more likely to make a mistake because you feel rushed. But take the appropriate amount of time to read medication labels—and read those that you're not familiar with twice. Converting milligrams to micrograms and calculating a pediatric dose from an adult dose are also potential pitfalls. So take extra time when you perform these tasks and ask another nurse to check your math.

Unclear orders are another problem. Verbal orders are particularly risky, especially when drugs have sound-alike names, such as Advair and Advicor. Prepare yourself by consulting the U.S. Pharmacopeia's list of commonly confused drugs at

www.usp.org/patientSafety/newsletters/qualityReview/qr7920-04-04-01.html. Consider posting the list so every nurse on your unit can refer to it. Written orders can be safer, but watch for illegible handwriting, misplaced zeros or decimal points, and frequently misread abbreviations. A list of such abbreviations (again, consider posting it) is available from the Institute for Safe Medication Practices, at www.ismp.org/msaarticles/specialissuetable.html. Of all written forms, electronic order entry is safest, but don't let your guard down. Electronic prescribing cannot detect all human error.

The bottom line? If the order doesn't make sense or is unclear, don't administer the drug. Ask the prescriber for clarification. If he or she is not available, speak to your supervisor and document your actions, including the date and time of your conversation, to whom you spoke and the outcome.

Finally, always review *all* of the five rights—right drug, right patient, right dose, right route and right time—before administering any drug. This helps avoid medication errors, enhances your patients' well being and reduces your risk of liability.



Questioning a doctor's orders

It is your right—and your responsibility—to question any order you think is inappropriate. In looking out for your patients' best interests, never shrug off a dubious order, trusting that "the physician knows best." Staying quiet could be viewed as negligence, leaving you, your nursing program and the facility vulnerable to a malpractice charge. As a student, you may not always trust your judgment, but following through on your concerns will help you gain confidence in your competence and professionalism, as well as protect you against liability.

The most crucial situation, of course, is when an order could compromise patient safety: for example, a physician gives an order that you know to be contraindicated, such as the wrong drug or the wrong dosage. It's also wise to question any order that is below the standard of care, or violates a hospital or employer policy or procedure. Never guess at an unclear or illegible order—always ask the practitioner exactly what he or she meant. Doing otherwise could compromise patient safety and

leave you facing disciplinary action.

You always have the option of bringing a concern about a doctor's orders to your preceptor or instructor for clarification and advice. If that advice includes speaking directly to the physician, be concise and provide specific reasons for your inquiry, such as a drug label's indication that the dosage ordered for your patient is dangerous. Be respectful but firm and professional, and don't back down until you are convinced the order is safe. If the doctor will not change the order, ask for an explanation or solid documentation to support his or her decision. Always take the time to document your objections, the person with whom you spoke about these objections, and what ensued.

Any nurse—including a student nurse—should never follow an unsafe order. In protecting your patient, you protect yourself as well, since carrying out an order despite serious doubts can leave you liable for a charge of malpractice and put your future license at risk.

DID YOU KNOW ...

About 17% of license protection claims involving RNs and NPs relate to medication errors. According to the National Coordinating Council for Medication Error Reporting, nearly 10% of lawsuits against hospitals involve a nurse who made a medication error. To learn more, read *Avoiding Medication Errors* at www.nso.com/medication. In the Know about Medication Errors at www.nso.com/intheknow and an actual case at www.nso.com/medcase.

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What is the right way to question orders? See page 7

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Nursing Students Ask

Answering your questions



Q When family members visit a loved one in the hospital, they often want to know more about the patient's condition. What can I tell them?
N.D., Dover, Delaware

A Since the implementation of the privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA), every facility should have established policies on ensuring patient privacy. It's essential that you follow them. Patients have the right to decide which relatives and friends, if any, they want to know about their condition—and every patient's decision should be documented.

If a patient does not want her health information revealed to a particular family member, explain the facility's privacy policy. If the patient has given her consent to reveal her health status to a certain relative and you have verified his identity, you can disclose the information, as long as you first check with the patient's primary nurse and your instructor and stay within your facility's guidelines for releasing the information.

Q I have a student policy, and have just graduated. Do I need to apply for another policy? K.D., Bellevue, Washington

A No, your current policy can be changed to cover you as a professional. If you are in renewal, your policy can be changed to professional status, making you eligible for the first-year graduate discount. If you are not in renewal, we can still add what's called a student-to-professional endorsement, which will cover you for license protection now that you carry one. Once your policy comes up for renewal, you will have the opportunity to update your coverage to full professional status so that you are properly covered. And, you can still receive up to a 50% first-year graduate discount on your premium. Your renewal statement will give you the option to continue to pay the student rate if it still applies, or the new professional rate with the discount already calculated for you. If you pay the new discounted professional rate, your policy will be updated to professional status once payment is received. Your policy number will remain the same.